Task Force to Study the Non-Group Health Insurance Market

Interim Report to the Legislature

December 15, 1999

Maryland Health Care Commission
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Executive Summary

In 1999, the Maryland General Assembly passed HB 43, *"Health Insurance – Standard Provisions – Task Force to Study the Non-Group Market."* While one purpose of the bill was to standardize certain contract provisions of insurers, nonprofit organizations and HMOs, a broader charge was to examine how well the nongroup market is working in terms of its access, affordability, and quality of coverage.

HB 43 (Chapter 602 of the Acts of 1999) established a thirteen-member Task Force, jointly chaired by the Insurance Commissioner and the Executive Director of the former Health Care Access and Cost Commission (HCACC), now known as the Maryland Health Care Commission (MHCC). The diverse membership of the Task Force included representation from the Maryland legislature, the Health Services Cost Review Commission (HSCRC), insurers, HMOs, underwriters, the Maryland Hospital Association, and the general public.

The statutory charge of the Task Force was to review and study the characteristics of the nongroup market, including: (1) an analysis and survey of nongroup products available; (2) the demographics of those insured in the nongroup market; (3) the affordability of nongroup products and pricing considerations in the nongroup market; and (4) trends in premium costs for nongroup products.

Based on an analysis of the nongroup market, the Task Force is charged with recommending whether changes should be made to state laws governing the nongroup market, taking into account and examining issues related to the following:

(1) the Health Insurance Portability and Accountability Act of 1997 (HIPAA);
(2) the Substantial, Available, and Affordable Coverage Program (SAAC);
(3) the small group market plan (CSHBP);
(4) health insurance coverage for self-employed and part time individuals;
(5) supplemental policies, including standardized and pre-standardized products, for Medicare;
(6) the creation of high risk pools;
(7) cross-subsidization between group and nongroup products; and,
(8) providing individuals with insurance through a list billing mechanism provided on a pre-tax dollar basis.

This report fulfills the statutory requirement for a preliminary report of findings and recommendations to the Governor and the General Assembly on or before December 15, 1999. A final report prepared by the Task Force is due on or before December 15, 2000.

The Task Force began meeting in June 1999 and has held eleven meetings to date. The group also conducted a sub-committee meeting in mid-September, to review a specific issue (SAAC).

The Task Force elected to prioritize discussing SAAC and make recommendations about the program in the interim report. From September through November, the Task Force received briefings on SAAC including a sample of SAAC products and sample rates of the four participating SAAC carriers. The Task Force received recommendations from staff, MAMSI, and CareFirst on how to calculate the value of the SAAC differential. Significant issues included the breadth of the subsidy (SAAC only or other high-risk products), the value of the differential, the price of the SAAC product, and the benefits to be covered.

This report contains the following conclusions and recommendations on these issues:

- SAAC should not be narrowly focused only on reducing the cost of hospital uncompensated care, but instead, should look more broadly at how carriers subsidize the premiums of comprehensive insurance products to make coverage more available and affordable.

- SAAC should not simply hold carriers harmless for subsidizing high risk individuals, but should provide an incentive for carriers to provide affordable coverage for populations that would otherwise be uninsured.

- Benefit design issues for the SAAC product should be reviewed by a workgroup convened by MHCC (formerly HCACC) who designed the current proposed benefit plan.

Based on these findings, the Task Force proposes that the Maryland General Assembly enact legislation, whenever necessary, to codify the following changes into the Insurance Code of Maryland:

SAAC Funding Formula:

- The SAAC differential granted to carriers in recognition of their providing open enrollment in the nongroup market should be 2%.

- The public benefit of SAAC should be measured in terms of how much the premium for the open enrollment product has been subsidized by the carrier to make it more affordable for the individual.

- The subsidy of the SAAC product should be defined as all expenditures for healthcare services in excess of 70% of the total premium for the SAAC product. The Task Force felt 70% was a reasonable loss ratio as compared to the standard statutory loss ratio of 60% in the individual market and 75% in the small group market.

- The test to determine whether a carrier has earned the differential should be to compare the value of the 2% differential to the carrier, (the difference between what the carrier would have paid for hospital services absent the differential

minus what the carrier paid for hospital services with the differential), to the amount the carrier subsidized the open enrollment product, times two. In general, the Task Force believed allowing carriers to retain benefits up to twice their subsidy would be an incentive to participate in the program.[1] Any economic benefit above two times the subsidy would have to be returned by the carrier. This could be done by making a payment to the HSCRC or its designee or by lowering the carrier's differential.

Operation of SAAC:

- The Insurance Commissioner should require a SAAC carrier's open enrollment premiums to be ***at least*** 5% higher than the small group market premiums or benefit–equivalent medically underwritten, individual product premiums.

- The Insurance Commissioner should prohibit specific age or geography banding of the SAAC product's community rate. However, by shadow pricing the SAAC product with the small group product, age and geography will be taken into account since rate banding for these factors is allowed in the small group market.

- Carriers should, at a minimum, hold two standard month-long open enrollment periods, per year, that meet current HSCRC advertising requirements. In order to allow consumers to better compare premium prices, all SAAC carriers should market their products in January and July to become effective within a month. Carriers can hold more than two open enrollment periods if they choose.

- Advertising the SAAC product should: a) occur at least twice a year in conjunction with the open enrollment period; b) be encouraged by executive branch agencies through public service announcements, fliers, etc., whenever feasible; and c) be promoted by requiring all individual market carriers (SAAC and non-SAAC) to send consumers information about the SAAC program, along with letters of declination for medically underwritten coverage.

[1] At least two SAAC carriers did not support this recommendation.

I. Introduction

In 1993, the Maryland legislature responded to concerns about the unavailability of health insurance in the small group market (2-50 employees) by passing a series of reforms in the way insurance was sold to ensure access and availability. Since that time, the number of covered lives in the small group market has increased by more than 20% and the number and percentage of small businesses offering insurance has grown. In 1999, the Maryland General Assembly turned its attention to the nongroup market passing HB 43 "Health Insurance – Standard Provisions – Task Force to Study the Non-Group Market." While one purpose of the bill was to standardize certain contract provisions of insurers, nonprofit organizations and HMOs, a broader charge was to examine how well the nongroup market is working in terms of its access, affordability, and quality of coverage.

HB 43 (Chapter 602 of the Acts of 1999) established a thirteen-member Task Force, jointly chaired by the Insurance Commissioner and the Executive Director of the former Health Care Access and Cost Commission (HCACC), now known as the Maryland Health Care Commission (MHCC). The diverse membership of the Task Force included representation from the Maryland legislature, Health Services Cost Review Commission (HSCRC), insurers, HMOs, underwriters, the Maryland Hospital Association, and the general public (See attachment following this section for a listing of Task Force representatives and their affiliation).

The statutory charge of the Task Force was to review and study the characteristics of the nongroup market, including: (1) an analysis and survey of nongroup products available; (2) the demographics of those insured in the nongroup market; (3) the affordability of nongroup products and pricing considerations in the nongroup market; and (4) trends in premium costs for nongroup products.

Based on an analysis of the nongroup market, the Task Force is charged with recommending whether changes should be made to state laws governing the nongroup market, taking into account and examining issues related to the following:

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(4) health insurance coverage for self-employed and part time individuals;
(5) supplemental policies, including standardized and pre-standardized products, for Medicare;
(6) the creation of high risk pools;
(7) cross-subsidization between group and nongroup products; and
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This report fulfills the statutory requirement for a preliminary report of findings and recommendations to the Governor and to the General Assembly on or before December 15, 1999. A final report prepared by the Task Force is due on or before December 15, 2000.

The Task Force began meeting in June 1999 and has held eleven meetings to date. The group also conducted a sub-committee meeting in mid-September, to review a specific issue (SAAC) which was attended by a majority of the Task Force members.

The Task Force held several informational briefings during the summer. These included presentations by Katherine Swartz of the Harvard School of Public Health, and Deborah Chollet of the Alpha Center on the experience of other states with nongroup market reform, specifically underwriting reforms and high-risk pools. Staff and carriers also provided information on insurance products currently available in Maryland including medically underwritten products for healthy individuals, open enrollment products for those with health problems and guaranteed issue products for the self-employed or those who change employment status. Products required to be offered under the HIPAA and Medicare supplement products also were addressed. In addition, staff presented information on the premium rates for the open enrollment, medically underwritten and small group products, as well as the trend in premiums for these products over the past three years. Finally, as part of the overview of the nongroup market, staff prepared a paper on the demographics of individuals who purchase nongroup coverage, as compared to the uninsured, and an analysis of pricing considerations and trends (see Sections II and III).

Having established a baseline understanding of current nongroup market dynamics, the group elected to focus its initial efforts on the open enrollment product; i.e., the SAAC program administered by the HSCRC. The SAAC program, created in the early 1970s by the HSCRC, principally covers those who cannot otherwise purchase insurance in the nongroup market due to a preexisting medical condition. Carriers who offer the SAAC product are currently given a 4% differential on regulated hospital charges for their entire book of business to subsidize their coverage of people who are likely to be sick. In recent years, HSCRC questioned the relationship between the value of the subsidy to carriers and the benefits offered. In 1997, at the HSCRC's request, the legislature required HCACC to develop a standardized benefit package for the SAAC program that would ensure comprehensive coverage. Regulations to implement changes in the SAAC benefit plan are currently pending due to objections from carriers concerning the proposed breadth of coverage and subsidy to be required for the program.

For these reasons, the Task Force elected to prioritize discussing SAAC and make recommendations about the program in the interim report. From September through November, the Task Force received briefings on SAAC including a sample of SAAC products and sample rates of the four participating SAAC carriers. The Task Force received recommendations from staff, MAMSI, and CareFirst on how to calculate the value of the SAAC differential. Significant issues included the breadth of the subsidy (SAAC only or other high-risk products), the value of the differential, the price of the

SAAC product, and the benefits to be covered. This report contains recommendations on these issues (See Section IV).

Having addressed in the interim report coverage issues for the most vulnerable population who cannot purchase a nongroup medically underwritten product, the Task Force will focus on issues of access and availability in all nongroup products, including those medically underwritten, in the final report. Specifically, the Task Force will address whether options exist to encourage the uninsured to purchase coverage in the nongroup market.

II. Demographics

Chapter 602 of the Acts of 1999 requires a profile of the demographics of the non-group market. Data used in this preliminary report primarily utilizes information abstracted from the Current Population Survey. It is generally agreed that, in order to account for sampling limitations, two to three years of data should be averaged. However, the tables in the preliminary report using the CPS data are based on only 1997 data. Before finalizing this report, the analysis will be expanded to include at least two years of CPS data.

The report contains information about the uninsured as well as about people in the non-group market for several reasons. National data can give a number of demographic snapshots of the people who buy insurance in the non-group market and also of those who are uninsured. By understanding the demographics of both groups and comparing national and Maryland-level data, questions about whether the non-group market is covering all the people who want insurance can be addressed. In addition, information about the uninsured can lead to an understanding of that population in order to target expansion of coverage.

National data for describing the two populations is examined in this report. It also, where available, provides Maryland-level information that may be more relevant. There are less state-level data than national data available. By comparing and contrasting the demographics of the Maryland population to those of the national population, different conclusions may be drawn about making coverage available in the non-group market and about expanding coverage to the uninsured. The report draws out the demographic information that could be useful in determining what sort of solutions, if any, address both the issue of any non-group market reform and the need to help expand coverage to the uninsured.

Data on health insurance coverage in the U.S. and in Maryland used in this report are primarily taken from an analysis of the Current Population Survey (CPS) by the Employee Benefit Research Institute (EBRI). The CPS is a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics and is the primary source of information on the labor force characteristics of the U.S. population. The sample is scientifically selected to represent the civilian non-institutional population. The CPS is a survey of everyone in a particular household. Respondents are interviewed to obtain information about the employment status and other information pertaining to each member of the household 15 years of age and older The CPS includes less than 1,000 Maryland households and Maryland data are then extrapolated from that survey. It is generally acknowledged that CPS overestimates the number of the uninsured population. Other data utilized in this report are tabulated by the Maryland Health Care Commission (MHCC) using Behavioral Risk Factor Surveillance System (BRFSS) data averaged for 1996 and 1997. The BRFSS is a state-based survey of non-institutionalized adults 18 years and older conducted by the 50 states in cooperation with the Centers for Disease Control and Prevention. It is a population-based, random digit-dialed telephone survey of individuals. The BRFSS data is garnered from a larger

Maryland population of approximately 2200 to 2400 individuals. It is generally acknowledged that the BRFSS underestimates the uninsured population.

The National and Maryland Health Insurance Market

As a vast majority of those people age 65 and older can receive health insurance through Medicare, all references in this report are to the non-elderly population who are insured through the private market, receive public assistance (Medicaid or Medicare disabled), or are uninsured. When analyzing the non-elderly population by selected source of health insurance coverage, a comparison of the national data to Maryland data yields some interesting information (Table 1). Nationally 64.2% of the population obtains coverage through employer-based policies, while, in Maryland, 72% of the population gets its insurance through that vehicle. Similarly, the non-group market in Maryland insures 7.4% of the population while only 6.7% of the population are covered in that market nationally. Conversely, in Maryland, there is a lower percentage of both those receiving care through public programs and the uninsured population than at the national level. National statistics for publicly assisted people and the uninsured are 14.8% and 18.3%, respectively, as compared to 10.1% and 14.9%, respectively, in Maryland. It appears that Maryland has been more successful in having its residents enrolled in private insurance policies than is the case at the national level. Almost 8 out of 10 Maryland residents are covered through private insurance while only 7 out of 10 people nationally are covered in that manner.

TABLE 1

Non-elderly Population with Selected Sources of Health Insurance, 1997

Source of Insurance	Maryland	Maryland (Percentage)	U.S (Millions)	U.S. (Percentage)
Employer-Based	3,186,505	72.0%	151.7	64.2%
Non-Group	328,210	7.4%	15.8	6.7%
Public	445,351	10.1%	34.9	14.8%
Uninsured	661,535	14.9%	43.1	18.3%
Total*	4,423,303	100.0%	236.2	100.0%

Source: EBRI tabulations of the March 1998 CPS.
*Details may not add to totals because individuals may receive coverage from more than one source.

A. The Non-Group Insurance Market

As noted above, nationally, a little under 7% and, in Maryland, a little over 7% of the non-elderly population receive their health insurance coverage through a non-group product.

Age: In both Maryland and nationally, the majority of those insured in this market are either children or adults of childbearing age. However, the distribution of age groups is quite different when comparing the Maryland numbers to national figures (Table 2). Nationally, less than a quarter of the non-group population are children,

whereas, in Maryland, children account for over a third of that market. The percentage of young adults aged 18 to 24 in the non-group market is almost twice as large in Maryland at 17.3% than nationally at 9.5%. Conversely, while nationally the older adult population (ages 45 to 64) accounts for about 36% of the non-group market, in Maryland, that same age group is only 23% of that market. These data demonstrate that a greater proportion of the Maryland non-group market is composed of younger people than is the case in the country, as a whole.

Another difference between Maryland and national demographics can be seen by comparing those insured through the non-group market to the population insured through an employer. Nationally, people over 45 years make up a larger percentage of the non-group market (36.4%) than they do in the employer-based market (26.2%). However, in Maryland, the reverse is true: only 23.4% of the non-group market are over 45 years while 28% with employer-based coverage fall into that age group.

TABLE 2

Health Insurance Coverage of Non-elderly Population by Age
Percentage within Coverage Category, 1997

Age	Total Population		Employer-Based		Non-Group		Uninsured	
	U.S	Maryland	U.S	Maryland	U.S.	Maryland	U.S.	Maryland
0-17	30.2%	28.2%	28.2%	27.6%	**22.9%**	**35.7%**	25.0%	19.1%
18-24	10.6%	9.3%	9.1%	6.3%	**9.5%**	**17.3%**	17.6%	18.0%
25-44	35.3%	37.0%	36.3%	38.2%	**31.1%**	**23.7%**	38.9%	43.5%
45-54	14.5%	15.9%	16.2%	17.9%	**17.9%**	**10.1%**	11.0%	12.6%
55-64	9.5%	9.6%	10.0%	10.1%	**18.5%**	**13.3%**	7.4%	6.8%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source for Maryland data: EBRI tabulations using 1998 CPS.
Source for U.S. data: Alpha Center tabulations using 1998 CPS.

Income: In terms of income, national numbers show that about 50% of those covered in the non-group market are in families that earn over $30,000 per year while about 14% of them are in families that earn less than $10,000 (Table 3). In comparison, almost 82% of those covered through their employers have a family income over $30,000 while less than 2% of the population with employer-based insurance have a family income less than $10,000.

TABLE 3

Insurance Coverage of U.S. Non-elderly Population by Family Income
Percentage within Coverage Category, 1997

Family Income	Employer-based	Non-Group	Public	Uninsured
Under $5,000	**0.8%**	**7.0%**	13.2%	11.6%
$5,000-$9,999	**1.1%**	**7.0%**	20.1%	8.8%
$10,000-$14,999	2.2%	8.2%	14.9%	12.5%
$15,000-$19,999	3.8%	7.6%	10.3%	10.9%
$20,000-$29,999	10.3%	16.5%	13.2%	17.9%
$30,000-$39,999	**12.8%**	**12.0%**	8.3%	11.8%
$40,000-$49,999	**12.7%**	**10.1%**	5.4%	8.6%
$50,000 and over	**56.4%**	**31.6%**	14.6%	18.1%
Total	100.0%	100.0%	100.0%	100.0%

Source: EBRI tabulations of the March 1998 CPS.

Nationally, the non-group market is surprisingly consistent with relatively equal proportions of the population being covered in that market irrespective of family income (Table 4). At all levels of income between 0% and 399% of Federal Poverty Level (FPL), the rate of non-group health insurance coverage ranges from about 7% to 9%. Only at above 400% FPL does the rate drop slightly to 5.3%. As pointed out in the Alpha Center study, "[t]he relatively high rate of individual insurance purchase among people with relatively low family income is consistent with less access to employer-based coverage among this population – and therefore, greater demand for individual insurance despite obvious constraints on their ability to afford it."

TABLE 4

Insurance Coverage of U.S. Non-elderly Population by Poverty Level
Percentage within Poverty Level Group, 1997

% of FPL	Employer-Based	Non-Group	Public	Uninsured	Total
0-99%	13.7%	**8.2%**	47.6%	34.8%	100.0%
100%-124%	29.4%	**7.8%**	31.4%	37.3%	100.0%
125%-149%	40.2%	**8.8%**	22.5%	34.3%	100.0%
150%-199%	53.1%	**8.1%**	16.1%	28.4%	100.0%
200%-399%	73.4%	**6.7%**	8.4%	15.4%	100.0%
400%+	85.3%	**5.3%**	4.7%	7.7%	100.0%
Total	64.2%	**6.7%**	14.8%	18.2%	100.0%

Source: EBRI tabulations of the March 1998 CPS. (U.S. Non-elderly Population = 236.2 million).

In Maryland, there is less consistency within the non-group market when viewing the distribution by poverty level (Table 5). Interestingly, over one out of every five people in families earning less than 100% of FPL are insured through the non-group market.

However, only one in 20 of those earning between 100% and 124% of FPL have non-group coverage while about one in 10 of those earning between 125% and 200% of FPL are covered in that market. From 200% FPL and above, Maryland numbers are roughly equivalent to national figures.

TABLE 5

Insurance Coverage of Maryland Non-elderly Population by Poverty Level
Percentage within Poverty Level Group, 1997

% of FPL	Employer-Based	Non-Group	Public	Uninsured	Total
0-99%	12.0%	**21.8%**	30.5%	41.3%	100.0%
100%-124%	25.8%	**5.5%**	38.8%	40.1%	100.0%
125%-149%	46.2%	**9.6%**	35.4%	23.7%	100.0%
150%-199%	43.1%	**11.6%**	13.5%	36.3%	100.0%
200%-399%	77.7%	**6.3%**	7.1%	12.9%	100.0%
400%+	87.7%	**4.7%**	5.4%	6.0%	100.0%
Total	72.0%	**7.4%**	10.1%	14.9%	100.0%

Source: EBRI tabulations of the March 1998 CPS. (Maryland Non-elderly Population = 4.4 million).

Nationally, the percentage of those covered by non-group health insurance increases as income increases up to 400% FPL (Table 6). Approximately 17% of individuals buying insurance in the non-group market have incomes less than 100% FPL; over 20% have incomes between 100% and 200% FPL; and almost 33% have incomes between 200% and 400% FPL. Those who have incomes over 400% FPL comprise a little over 28% of the non-group market. By comparison, in Maryland, the proportion of non-group covered lives is higher than national figures for the poorest families. Almost 25% of the non-group market live in families who earn less than 100% of FPL. Above 100% of FPL, the Maryland statistics are closer to the national numbers with those earning between 100% and 199% of FPL comprising almost 20% of the non-group market; 26% of the market earning between 200% and 400% FPL; and the rest of the market (30%) earning over 400% FPL.

TABLE 6

Non-Group Coverage of U.S. and MD Non-Elderly Population by Poverty Level, 1997

% of FPL	Non-Group	
	U.S.	Maryland
0-99%	17.1%	24.5%
100-124	5.1%	1.4%
125-149	5.7%	2.8%
150-199	10.8%	14.8%
200-399	32.9%	26.0%
400+	28.5%	30.4%
Total	100.0%	100.0%

Source: EBRI tabulations of the March 1998 CPS.

Gender: Although it may be difficult to surmise how gender affects the non-group market, there could be an effect on the type of policies being sold or the types of pre-existing condition limitations that may be attached to non-group policies. Table 7 shows the differences between Maryland and U.S. demographics. Nationally, 6.2% of males receive health insurance through the non-group market whereas 6.9% of females do. In Maryland, males and females are almost equal in the percentage that receive non-group coverage: 6.7% and 6.6%, respectively. The ratio of male to female in the non-group market nationally is approximately 47% to 53% while Maryland is almost exactly half female and half male in that market.

TABLE 7

Insurance Coverage by Gender, 1997

Gender	Percent of Total Population		Percent Within Coverage Category	
	Non-Group Maryland	Non-Group U.S.	Non-Group Maryland	Non-Group U.S.
Male	6.7%	6.2%	49.7%	46.7%
Female	6.6%	6.9%	50.3%	53.3%

Source: EBRI tabulations of the March 1998 CPS.

Firm Size: An analysis of insurance coverage by firm size demonstrates generally understood principles governing the health insurance market. Large employers offer group coverage because they can employ economies of scale and can pool risks. As such, as firm size decreases, so do the number of workers with employer-based coverage. Conversely, those with non-group coverage (and the uninsured) increase. In Maryland, 15% of workers employed in a firm with less than 10 employees are covered by non-group insurance (Table 8). In fact, at all levels of firm size above 25 employees, less than 5% of the workers within that firm-size category are covered with non-group policies. In those same categories, 78% or higher have insurance through their employer. The pattern is similar within coverage category as well (Table 9): almost 75% of all workers with non-group coverage work in firms with less than 100 employees, and over 40% work in firms with under 10 employees.

TABLE 8

Maryland Workers (Ages 18-64) with Selected Sources of Health Insurance by Firm Size
Percentage within Firm-Size Category, 1997

Firm Size	Employer-based	Non-group	Public	Uninsured	Total
Under 10	45.3%	**15.1%**	3.9%	38.0%	100.0%
10 to 24	57.7%	12.8%	5.3%	25.6%	100.0%
25 to 99	**78.0%**	**4.8%**	1.6%	17.2%	100.0%
100 to 499	**82.5%**	**4.7%**	3.8%	11.3%	100.0%
500 to 999	**89.0%**	**0.0%**	6.6%	11.0%	100.0%
1000 and over	**86.1%**	**2.3%**	6.5%	8.8%	100.0%
Total	75.1%	6.0%	5.0%	16.8%	100.0%

Source: EBRI tabulations of the March 1998 CPS.

TABLE 9

Maryland Workers (Ages 18-64) with Selected Sources of Health Insurance by Firm Size
Percentage within Coverage Category, 1997

Firm Size	Employer-based	Non-group	Public	Uninsured
Under 10	10.2%	**43.0%**	13.2%	38.2%
10 to 24	7.3%	**20.5%**	10.0%	14.5%
25 to 99	14.1%	**10.9%**	4.3%	13.9%
100 to 499	11.3%	8.1%	7.9%	6.9%
500 to 999	4.7%	0.0%	5.3%	2.6%
1000 and over	52.3%	17.6%	59.3%	23.9%
Total	100.0%	100.0%	100.0%	100.0%

Source: EBRI tabulations of the March 1998 CPS.

Self-Employed: Maryland and national statistics on the self-employed by selected source of health insurance are almost identical (Table 10). Both have just over 50% receiving insurance through employer-based coverage. Many of these self-employed individuals are independent contractors who receive health insurance through their main employer. Approximately 20% of the self-employed nationally and in Maryland utilize a non-group product. Less than 5% receive public health insurance and about 25% of both the national and Maryland self-employed are uninsured.

TABLE 10

Self-employed (Ages 18-64) with Selected Sources of Health Insurance, 1997

Source of Insurance	Maryland		U.S. (millions)	
Employer-Based	124,775	51.7%	6.3	52.5%
Non-Group	46,650	19.3%	2.5	20.5%
Public	11,073	4.6%	0.6	4.8%
Uninsured	66,425	27.5%	2.9	24.1%
Total	241,504	100.0%	12.1	100.0%

Source: EBRI tabulations of the March 1998 CPS.

B. The Uninsured Population

While it is important to understand the demographics of the Maryland non-group market in order to assess its viability especially in comparison to the non-group market nationally, it is perhaps of greater importance to understand the demographics of the uninsured in Maryland. By definition, those receiving coverage in the non-group market already have insurance. If the Maryland non-group market does not vastly differ from national demographics, it can be inferred that the non-group market in Maryland is

working, at least as well as it is in other states. As noted above, the non-group market in Maryland could be seen as being more effective than the country as a whole.

Understanding the demographics of the uninsured in Maryland can assist in fashioning strategies that could lead to the expansion of coverage to those populations who are in need of health insurance.

Age: Comparing national and Maryland percentages of the uninsured by age within coverage category shows very little difference (Table 11). The biggest difference is that only 1 out of every 5 uninsured Marylanders is a child less than 17 years old while, nationally, children account for 1 out of every 4 uninsured people. This difference could either be attributable to larger amounts of Maryland residents having private insurance (both employer-based and non-group), the State being relatively successful in its public outreach to uninsured children, or both. There is not enough difference in age distribution between the Maryland population and the total U.S. population to account for the marked difference in uninsured children in Maryland.

TABLE 11

Non-elderly Uninsured Population by Age
Percentage within Coverage Category, 1997

Age	Total Population		Uninsured	
	U.S.	Maryland	U.S.	Maryland
0-17	30.2%	28.2%	**25.0%**	**19.1%**
18-24	10.6%	9.3%	17.6%	18.0%
25-44	35.3%	37.0%	38.9%	43.5%
45-54	14.5%	15.9%	11.0%	12.6%
55-64	9.5%	9.6%	7.4%	6.8%
Total	100.0%	100.0%	100.0%	100.0%

Source: EBRI tabulations of the March 1998 CPS.

Although children ages 0-17 account for almost 20% of the uninsured, only 10% of all children are uninsured (Table 12). However, a look at age groups between 18 and 29 years yields a different story. In the age ranges of 18-20, 21-24, and 25-29, between one quarter and one third of each age group are uninsured. These percentages are much higher than the state average of only 15%.

TABLE 12

Maryland Non-elderly Uninsured Population by Age, 1997

Age	Number of Uninsured	Uninsured within Age Group	Uninsured within Coverage Category
0-17	126,362	**10.1%**	19.1%
18-20	48,916	**24.3%**	7.4%
21-24	70,238	**33.7%**	10.6%
25-29	97,305	**23.4%**	14.7%
30-44	190,542	15.6%	28.8%
45-54	83,432	11.8%	12.6%
55-64	44,740	10.5%	6.8%
Total	661,535	**15.0%**	100.0%

Source: EBRI tabulations of the March 1998 CPS. (Maryland Non-elderly Population = 4.4 million).

Income: The Health Care Access and Cost Commission (HCACC), using data from the BRFSS for 1996 and 1997, has made some estimates about the uninsured population in Maryland (Table 13). As one would expect, more than 47% of uninsured adults in Maryland have an annual household income of less than $25,000. Those who earn between $25,000 and $35,000 per year account for another 23% of the uninsured. The most interesting statistic shows that almost 15% of the uninsured earn more than $50,000 per year. Nationally, CPS data show that 18% of the uninsured earn over $50,000 per year.

TABLE 13

Uninsured Maryland Adults (18-64 years) by Annual Household Income, 1996-97

Income	Percent of Uninsured
Up to $24,999	47.5%
$25,000 to $34,999	23.3%
$35,000 to $49,000	14.7%
$50,000 and above	14.5%
Total	100.0%

Source: HCACC tabulations of 1996-1997 BRFS data.

According to EBRI data, the distribution of the uninsured by poverty level in Maryland is somewhat different that the national distribution (Table 14). A slightly smaller percentage of the uninsured in Maryland earns less than 100% of FPL than the nation as a whole (23% versus 26.5%). There are only half as many uninsured earning between 100% and 149% of FPL in Maryland than nationally (8% versus 16%). However, in Maryland 23%

of the uninsured earn between 150% and 199% of FPL while, nationally, only 14% of the uninsured are in that poverty level group. Maryland also has a higher percentage of uninsured who earn over 400% of FPL (19%) than is reflected in national figures (15%).

TABLE 14

Uninsured U.S. and Maryland Non-elderly Population by Poverty Level
Percentage within Coverage Category, 1997

% of FPL	U.S. (millions)		Maryland	
0-99%	11.4	**26.5%**	151,989	**23.0%**
100%-124%	3.8	**8.8%**	33,855	**5.1%**
125%-149%	3.5	**8.1%**	23,086	**3.5%**
150%-199%	6.0	**13.9%**	152,804	**23.1%**
200%-399%	11.9	27.6%	173,324	26.2%
400%+	6.5	**15.1%**	126,478	**19.1%**
Total	43.1	100.0%	661,535	100.0%

Source: EBRI tabulations of the March 1998 CPS.

Information about uninsured Maryland children by poverty rate is available using CPS data (Table 15). Again, it is not surprising that a majority of uninsured children come from families earning less than 200% of the FPL. Almost 38% of uninsured Maryland children are found in families earning less than 100% of the FPL and another 27% are in families earning between 100% and 200% FPL. As seen above with the adult population, a larger percentage of uninsured children live in families with income at 400% FPL or higher in Maryland than in the U.S. as a whole (19.0% versus 8.4%).

TABLE 15

Uninsured Children (U.S. and Maryland) by Poverty Level, 1997

% of FPL	U.S. (millions)	U.S. (Percentage)	Maryland	Maryland (Percentage)
0-99% FPL	3.6	33.6%	47,889	**37.9%**
100-149% FPL	2.1	20.0%	9,251	**7.3%**
150-199% FPL	1.6	15.0%	25,436	**20.1%**
200-399% FPL	2.5	23.4%	19,735	15.6%
400% FPL +	0.9	8.4%	24,051	**19.0%**
Total	10.7	100.0%	126,362	100.0%

Source: EBRI tabulations of the March 1998 CPS.

Gender: A comparison of Maryland data to national data on the uninsured by gender does not show great differences (Table 16). In Maryland, about 19% of males and 15% of females are uninsured while, nationally, the percentages are 21% and 17% respectively. The ratio of uninsured males to uninsured females both at the Maryland level and nationally are almost identical (1 to .79 for Maryland and 1 to .81 nationally)

and the lower absolute percentages in Maryland probably reflect the overall lower uninsured rate. The ratios of male to female within the uninsured population also are very similar.

TABLE 16

Uninsured by Gender, 1997

Gender	Percent of Total Population		Percent Within Coverage Category	
	Uninsured Maryland	Uninsured U.S.	Uninsured Maryland	Uninsured U.S.
Male	19.2%	21.0%	56.0%	54.5%
Female	14.6%	16.9%	44.0%	45.5%

Source: EBRI tabulations of the March 1998 CPS.

Firm Size: Data on uninsured workers by firm size in Maryland again tracks conventional knowledge. A majority of the uninsured, over 66%, works for firms with less than 100 employees (Table 17). It is difficult to determine how much of that percentage is attributable: (1) to employers not offering health insurance at all (although a number of recent studies have shown that employer offer rates are actually increasing); (2) to the possibility that wages are relatively lower in those firms and employees feel they can not afford whatever proportion of the premium they would be required to pay; or (3) to the possibility that smaller firms have a disproportionate number of younger workers who choose not to buy health insurance as they feel they are healthy and do not need it. Related to the affordability issue is a well-documented trend that employers are contributing a lower proportion toward health insurance premiums than they had in the past. Again, the interesting statistic shows that almost one quarter of uninsured workers are employed in firms with over 1000 employees. In most cases these firms are offering health insurance, but there are no data available to know whether these workers are simply choosing not to buy insurance or whether premiums are unaffordable.

TABLE 17

Uninsured Maryland Workers (Ages 18-64) by Firm Size, 1997

Firm Size	Number of Uninsured	Uninsured within Firm Size Group	Uninsured within Coverage Category
Under 10	176,962	38.0%	**38.2%**
10 to 24	67,367	25.6%	**14.5%**
25 to 99	64,257	17.2%	**13.9%**
100 to 499	31,951	11.3%	6.9%
500 to 999	12,103	11.0%	2.6%
1000 and over	110,743	8.8%	**23.9%**
Total	463,383	16.8%	100.0%

Source: EBRI tabulations of the March 1998 CPS.

Self-employed: As noted in the section on the non-group market, Maryland and national statistics on the self-employed, by selected source of health insurance, are almost identical (Table 18). About 25% of both the national and Maryland self-employed are uninsured. The most interesting information is the actual number of uninsured self-employed people at over 66,000 people. This number accounts for approximately 10% of all uninsured people in Maryland. This group could be targeted for coverage as the Comprehensive Standard Health Benefit Plan of the small group market is available to them. Of course, income levels of the self-employed could influence the level of coverage in that population, as it does in the population in general.

III. Non-Group Products

A. Analysis and Survey of Non-Group Products Available In Maryland

Products available in the individual market in Maryland include the open enrollment or "SAAC" policies[2], medically underwritten policies, conversion policies, HIPAA policies, and the small group policies offered to self-employed individuals. The characteristics of these products vary considerably in terms of benefits and cost sharing.[3] Moreover, except for the small group product, which has a standardized benefit plan and uniform cost sharing, there is also a wide degree of variability within each product type, most evident in the SAAC product. The following description of the array of products offered in the Maryland nongroup market will highlight some of the characteristics of these different nongroup products.

SAAC

Parameters for the SAAC product are set by COMAR 10.37.10. Until recently,[4] there were few guidelines regarding benefit requirements for SAAC products other than those set forth in COMAR 10.37.10, and existing mandated benefits applicable to all non-group products, such as coverage for cleft lip/cleft palate. See Insurance Article §15-818, Annotated Code of Maryland. In addition to mandated benefits, SAAC products offered by health maintenance organizations ("HMOs") contain certain minimum benefits as required by Health-General §19-701(f)(2), because HMOs are required to offer these minimum benefits in all of their products as a condition of HMO licensure. Examples of these include physician, hospitalization, laboratory, x-ray, emergency and preventive services. See Health-General §19-701(f)(2).

A comparison between the two SAAC insurance products offered by CareFirst, Inc., CareFirst of Maryland ("CareFirst)" and Group Hospitalization and Medical Services, Inc. ("GHMSI") highlights the discrepancies in benefits, even between two SAAC insured products.[5] In general terms, the CareFirst plan covers hospital charges for 30 days and offers limited office visits, usually in areas prescribed by statute as mandated benefits for all policies in the individual market, such as child wellness, mammography, and maternity. See Insurance Article §§15-817, 15-814, and 15-811-812. However, even coverage for the mandated benefits is limited under the CareFirst plan. While GHMSI covers 100% of in-network charges less a $25 member co-pay per visit for child wellness

[2] For further discussion of SAAC, see pages 26-27 in Section IV.
[3] Indemnity/PPO offerings typically allow for cost sharing that is based upon a percentage of the total claim, while traditional HMO offerings generally have a copay framework.
[4] See Appendix A of this report for a reference to recent regulations proposed by the HCACC regarding a standard benefit package for the SAAC product.
[5] The CareFirst product pays participating providers according to a fee schedule. See Attachment 2. The GHMSI product offers a preferred provider network ("PPO") from whom the insured can obtain services with a lower deductible and lower co-insurance percentage as compared to obtaining the same services from out-of-network providers.

visits, CareFirst caps the coverage at $47 for an office visit, and up to $31 for immunizations and laboratory tests. For mammography, GHMSI covers 100% of the cost while CareFirst covers only up to $82 for diagnostic services and $44 for related screening services. For maternity, CareFirst is limited to inpatient hospital charges at 80% for up to 30 days per benefit period, and physician inpatient charges of up to $550 for a C-section or $250 for a vaginal delivery, while the GHMSI plan covers 80% in-network and 65% of out-of-network inpatient hospital charges. See Attachment 1, p. 2.

Further, CareFirst pays for no office visits, adult preventive physical exams, or skilled nursing facility services, while GHMSI covers 100% less a $25 co-pay for office visits and adult preventive exams, and 80% of in-network skilled nursing facility charges up to 60 days per year. See Attachment 1, pp. 2, 3. In sum, both of these SAAC insurance policies meet SAAC regulation requirements under COMAR 10.37.10 and are approved SAAC policies, yet one is basically a hospital-only policy, and the other is a more comprehensive policy.

HMO SAAC policies are similar in terms of what benefits are offered, but vary in terms of cost sharing. As noted earlier, the similarity in benefits is due to the requirements of Health-General §19-701(f)(2), which prescribe that all HMOs cover certain services in all products they offer. Cost sharing varies as follows, between two HMO SAAC products offered by Optimum Choice, Inc. ("OCI") and the Free State Health Plan, Inc. ("Freestate"), which is a CareFirst HMO.

For child wellness, an OCI member pays a $10 co-payment per visit to a primary care provider, while Freestate covers 80% of the child wellness visits. Similarly, an OCI member pays a $20 co-payment for mammography while a Freestate member is responsible for 20% of the mammography charge. See Attachment 1, p. 2. Outpatient therapy is limited to 60 visits per condition combined for physical, speech and occupational therapy, subject to office visit co-payments for OCI members. For Freestate members, outpatient therapy service is covered up to 80%, and limited to 30 visits, per condition, per year, combined for physical and occupational therapy, and 30 visits, per condition, per year, for speech therapy. See Attachment 1, p. 3. Thus, two HMO products in the SAAC market vary in terms of payment structure: OCI uses a traditional HMO member co-pay framework, while Freestate's co-insurance for most benefits resembles more of an insurance cost-sharing product.

Medically Underwritten Products

The medically underwritten product in the nongroup market is a comprehensive product similar to a group product, including coverage for both inpatient and outpatient hospitalization services, adult preventive physical exams, office visits, hospice care, outpatient physical therapy services and outpatient prescription drugs, among other benefits. See Attachment 3. However, in order to obtain this type of insurance, an applicant is subject to medical underwriting, therefore the availability of this product to the uninsured in the individual market is limited to the healthier population who can pass

the carrier's medical underwriting.[6] For example, in 1998, there were 18,994 applications for CareFirst's medically underwritten policy; CareFirst issued 13,027 contracts.[7] Similarly, in 1998, Kaiser Foundation received 4,348 applications for its medically underwritten HMO product and issued 2,434 contracts. See Attachment 4, pp. 2, 3.

There are many different cost sharing arrangements available within the same carrier's medically underwritten product, and among the different carriers' products. One of CareFirst's policies can be purchased with the following range of deductibles: $100, $200, $400, $500, $750, $800, $1,000, $1,500, $2,500, $5,000 or $10,000. See Attachment 3, p. 1. The child wellness benefit cost sharing differs from carrier to carrier, including a $10 co-pay per visit (not subject to the deductible) under the CareFirst insured plan, and 100% coverage for an in-network provider visit less a $25 per visit co-pay under the GHMSI PPO plan. See Attachment 3, p. 2.

The HMO cost sharing varies as well: Child wellness coverage under OCI's plan is a $10 co-pay per visit. Under Freestate's Personal Plan, it is a $5 co-pay per visit for children over 5 years old, and under Freestate's Personal Advantage Plan, it is a $15 co-pay for children over 5 years old. See Attachment 3, p. 2. Further, outpatient prescription drug coverage fluctuates considerably among different carriers' products in terms of an annual maximum, ranging from $500 to $4,000. See Attachment 3, p. 5.

In sum, the medically underwritten policies are comprehensive in terms of benefit coverage because the risk to the carrier is minimized as compared to SAAC insureds, due to medical underwriting. Accordingly, the rates for the medically underwritten products are more affordable. For example, the Freestate SAAC product premium for an individual is approximately $265 a month for 1999, while one of Freestate's medically underwritten product's premium is $133 per month for the same year. See Attachment 5, p. 1, and Attachment 6, p. 1. Similarly, for 1999, OCI's monthly SAAC premium rate is $257.04 for an age 35 individual, while OCI's medically underwritten product's rate for an individual age 35 is less than half of the SAAC rate, at $155.79 per month. See Attachment 5, p. 1 and Attachment 6, p. 2.

Conversion Products

Maryland law mandates conversion product coverage. See Insurance Article, §§15-412, 15-414. An insured who has been covered under a group policy for at least 3 months and whose coverage is terminated for any reason other than failure of the insured to pay a required premium, shall have issued without evidence of insurability a converted policy providing benefits not less than the prescribed minimum benefits. See Insurance Article §15-412(c) and COMAR 31.11.01.05. For HMOs, the requirements are similar, and the

[6] As long as an applicant passes the carrier's medical underwriting requirements, an applicant can become insured at any time. By contrast, there are two 30-day open enrollment periods for the SAAC product, at least five months apart. COMAR 10.37.10.26.

[7] See Page 22 of this report for information on survey results.

benefits are richer than the insured products, due to the HMO requirements of Health-General §19-701(f)2. See COMAR 31.12.01.10. The conversion product has no medical underwriting and the product is guaranteed renewable, thus, it generally attracts a sicker population. See Insurance Article, §15-413. COMAR 31.11.01.11 sets forth minimum standards for the conversion product, that depends on the coverage of the original group policy from which the conversion was made.

Cost sharing varies dramatically among carriers' conversion policies. For example, for emergency services, CareFirst's insurance product pays the first $300 if care is received within 72 hours of an accident and $1,500 if safety equipment was used. Any emergency care cost over $300 or $1,500 is subject to the applicable deductible ($250 or $500) and co-insurance of 75%. See Attachment 7, p.1. By contrast, emergency services are subject to the applicable deductible and co-insurance for GHMSI's indemnity product. See Attachment 7, p.1. Cost sharing for emergency services under HMO products also varies from a $50 co-pay by Kaiser's policy, a 50% co-pay up to $50 by OCI's policy, and a $25 co-pay by Freestate's policy. See Attachment 7, p.1.

The durable medical equipment ("DME") benefit is another example of the wide differences among conversion policies in terms of cost sharing. CareFirst pays up to a $1,000 maximum; GHMSI pays 80% co-insurance after the insured pays the deductible ($500 or $1,000); Kaiser covers DME for three months following hospital confinement; OCI covers 50% of its cost; and Freestate covers DME 100%. See Attachment 7, p. 2. Finally, eye care is not offered as a benefit in two products, but Kaiser's policy offers the member a 25% discount and a 15% discount on glasses and contact lenses, respectively. See Attachment 7, p. 3. OCI's member pays a $25 co-pay for a first visit and a $5 co-pay for subsequent visits for refraction screening; and Freestate's member pays a $10 co-pay per visit for eye care. See Attachment 7, p.3.

While conversion coverage is fairly comprehensive as it is based on an initial group policy, its cost sharing characteristics are not as beneficial to the insured as a medically underwritten product. By regulation, an insurer can use 75% as its co-insurance percentage for a conversion policy (See CareFirst's conversion product, Attachment 7, p.1.), while CareFirst's medically underwritten product offers an 80% co-insurance option. See COMAR 31.11.01.11(B). By regulation, an insurer may use a $500 deductible for its conversion product and impose a lifetime maximum of $200,000 per person. See COMAR 31.11.01.11 (C) and (D). By contrast, the CareFirst medically underwritten product offers deductibles at $100, $200, $400, and $500 and a $1,000,000 lifetime maximum per insured. See Attachment 3, p. 1. Finally, the conversion product of an insurer can limit its annual benefit maximum to $50,000 which can fall short for a seriously ill insured; the medically underwritten product has no annual maximum[8]. See COMAR 31.11.01.11 (E).

In sum, Maryland law requires carriers to issue conversion products in the required circumstances; however, most insureds who can pass a carrier's medical underwriting

[8] HMOs are not subject to the above –referenced regulations, but are subject to the requirements of Health-General 19-701(f)2.

will opt for the latter rather than the conversion product. A carrier's conversion product rate is higher than its rate for its medically underwritten product because the pool of insureds with conversion contracts are less healthy than the pool of insureds who passed the carrier's medical underwriting criteria. According to carrier survey information for 1999, CareFirst has 34,304 medically underwritten contracts and 3,614 conversion contracts in force. See Attachment 4, p. 1.

HIPAA Products

Maryland's Health Insurance Portability and Accountability Act ("HIPAA") originated from federal law and was adopted by Maryland to establish some individual market reforms. See Insurance Article §15-1301. Among other things, it is available to those who have lost group coverage and to those who have had eighteen months of creditable coverage with an employer without a break in coverage of more than 63 days. See Insurance Article §§ 15-1301(g) and (h). A carrier is prohibited from medical underwriting, and in most cases, imposing pre-existing condition limits. See Insurance Article §§ 15-1304, 15-1308. In addition, the product is guaranteed issue and renewable. See Insurance Article §§ 15-1308(a) and 1309.

The carrier is required by law to offer a high-level and low-level product, or offer its two most popular contracts based on premium volume. See Insurance Article, §15-1306. As such, products differ in terms of cost sharing and benefit limits. CareFirst offers a product with a $400 or $800 deductible and 80% co-insurance, while the GHMSI plan offers a $100 or $300 in-network deductible with a 90%/80% co-insurance, and a $300 or $500 out-of-network deductible with a 70% or 60% co-insurance. See Attachment 8, p.1. Inpatient hospitalization reflects the panoply of options: The CareFirst insured pays his applicable deductible and co-insurance percentage, while a Kaiser HMO member pays a $500 co-payment per admission; the OCI member is covered in full or pays 20% co-insurance depending under which option the member is covered; and the Freestate Personal Advantage member pays a $500 co-pay per member per year, and a $1,500 co-pay per family per year. See Attachment 8, p. 3.

Outpatient prescription drug coverage also varies in terms of cost to the insured or member. Under the CareFirst plan, the insured pays the deductible and co-insurance, with a $500 per year maximum. See Attachment 8, p.3. The GHMSI insured pays a $100 deductible, in addition to a $10 co-pay for generic and a $20 co-pay for name brand drugs, with a $1,500 annual maximum above which the carrier will no longer cover drugs. See Attachment 8, p. 3.

The HMO cost sharing for HIPAA products differs as well: A member under Kaiser pays a $15 co-pay for a generic drug and a $15 surcharge for the difference in cost for a brand name drug, with a $1,500 annual maximum. See Attachment 8, p. 3. A member with OCI pays a $100 deductible, a $2 or $5 co-pay for generic or brand name drugs, with a $3,000 annual maximum. See Attachment 8, p. 3. Under the Freestate Personal Plan, a member pays a $5 co-pay with a $4,000 annual maximum, while under the

Freestate Personal Advantage Plan, a member pays a $50 deductible and a $15 co-pay, with a $1,000 annual maximum. See Attachment 8, p. 3.

While approximately 24 carriers offer a HIPAA product, its availability is limited by its price and eligibility requirements, notwithstanding the statutory requirement that carriers shall actively market their HIPAA product. See Insurance Article, §15-1304. Statute permits a carrier to charge twice as much for its HIPAA product as it charges for a similar policy in the individual market.

"A carrier that elects to offer a high level and low level policy form may not charge a rate to eligible individuals that is greater than 200% of the rate the carrier normally would charge for the same or similar policy forms to other individuals." See Insurance Article, §15-1306. In addition to HIPAA's high rates, most HIPAA eligibles have already paid high COBRA rates for 18 months prior to applying for HIPAA.

The product's availability is also limited by its strict eligibility requirements, such as prior coverage of 18 months without a break of more than 63 full days, and ineligibility for other group coverage and Medicare or Medicaid, among other requirements. See Attachment 9 (flow chart of HIPAA eligibility requirements). Accordingly, for 1998, CareFirst issued 454 HIPAA contracts for 719 applications. See Attachment 4, pp. 2, 3. Survey results reflect that healthy HIPAA eligibles prefer a less expensive, medically underwritten product over a HIPAA product.

Small Group Market

Maryland's small group market coverage is also available to those individuals who are self-employed. See Insurance Article §15-1201 (e)(1) and COMAR 31.11.07. The coverage is guaranteed issue and renewable, and employs modified community rating (+/- 40%), adjusting for age and geography. See Insurance Article §§15-1205 and 15-1212. All carriers in the market are required to offer the Comprehensive Standard Health Benefit Plan ("CSHBP"), as set forth in COMAR 31.11.06.[9] Carriers offer open enrollment twice a year during designated months [COMAR 31.11.07.03 (D)]. Some Task Force members have expressed concern about the ability of self-employed individuals to join the small group market only when there is a need for services. For example, an individual may join the market after becoming pregnant and leave the market after delivery; thus avoiding premium payments when there is no need for services (See minutes in Appendix C).

The CSHBP is offered through six delivery systems (indemnity, PPO, POS, HMO, Triple Option POS, and PPO/MSA). Deductibles are set by regulation for each plan type, including $200 in the POS plans and $500 in the PPO plans, for individual coverage[10]. Copays for HMOs are $10 for a primary care visit and $20 for a specialist visit and a

[9] Carriers may only offer riders to enhance benefits, not to reduce them. Riders also can be offered to decrease copays or deductibles.

[10] The deductible for individual coverage in a PPO plan will increase to $750, effective 7/1/2000.

physician inpatient visit. See COMAR 31.11.06.04 (F). Co-insurance for in-network services is 80%, and 60% for out-of-network services in PPO and POS plans. See COMAR 31.11.06.04 (F)(2). The annual out-of-pocket maximum varies for an individual, from $2,500 under a POS plan, to $3,000 for a PPO plan, to $3,500 for an indemnity plan, and 200% of the annual premium for an HMO member[11]. See Attachment 10. Each of these cost sharing arrangements per plan type is required by regulation [COMAR 31.11.06.04(F)]. The standard cost sharing arrangements per plan type coupled with the CSHBP make price comparison among plan types and carriers simpler than comparison of prices in other nongroup products in which benefits and cost sharing are not prescribed or standardized.

Survey of Carriers

In order to obtain more information from carriers regarding Maryland's non-group marketplace, the Maryland Insurance Administration ("MIA") surveyed approximately 24 carriers in the Maryland nongroup market, and 19 responded. See Attachment 4. First, the survey asked each carrier to report the number of contracts issued in 1999 by type of nongroup product, including medically underwritten, SAAC, HIPAA, conversion and small group for the self-employed. See Attachment 4. According to survey results, the largest writers in the SAAC market are Freestate, CareFirst, GHMSI, and OCI. See Attachment 4, p. 1. The largest writers in the medically underwritten market are CareFirst, Freestate, and the Kaiser Foundation. See Attachment 4, p. 1.

Second, for 1998, the survey requested information on the number of applications carriers received, and the number of contracts carriers issued for each product type, to glean the number of applicants who were excluded from non-SAAC policies and who could be potentially included in SAAC.[12] See Attachment 4, pp. 2, 3. In 1998, CareFirst received 18,994 applications for its medically underwritten product, and issued 13,027 contracts for that year, which yields a 32% rejection rate. OCI received 2,768 applications for its medically underwritten product and issued 2,215 contracts, which is a 20% rejection rate. For its SAAC product, Freestate received 864 applications and issued 674 contracts for a 22% rejection rate[13], while OCI's number of applications received was the same as the number of contracts issued .[14] (For HIPAA application rejection rates, see previous sub-section on HIPAA products).

[11] The out-of-pocket maximum for individual coverage in a PPO plan will increase to $3,400, effective 7/1/2000.

[12] It is unclear how accurate these figures are, as some third party administrators or agents pre-screen the applications, and only send to the carriers eligible applications.

[13] Rejection rate in this context does not necessarily reflect rejection by the carrier and may, instead, indicate that the consumer elects and qualifies for a medically underwritten product after applying for SAAC or becomes eligible for a group product.

[14] The HSCRC requested that OCI increase its membership to obtain the SAAC discount.

B. The Affordability of Non-Group Products and Pricing: Considerations in the Non-Group Market

The affordability of nongroup products is subjective as it is relative to each individual's disposable income, and must be considered in conjunction with the benefits included in each product. Unlike the small group market, the other nongroup products do not have uniform benefits or cost sharing, making price comparison difficult. For example, in the SAAC market, the CareFirst insurance product costs $103.58 per month for a 35-year-old individual, while OCI's HMO SAAC product for a 35-year-old individual costs $257.04 per month. See Attachment 5, p. 1. While CareFirst's product is less than one-half the cost of OCI's product, a comparison of the benefits reflects that OCI's product includes substantially more complete coverage than the CareFirst product. OCI's product includes 80% of hospital coverage with no limit, while CareFirst's product is 80% for up to 30 days. See Attachment 1, p. 1. OCI covers adult preventive physical exams less a $10 co-pay while CareFirst does not offer this benefit at all. See Attachment 1, p. 2. Similarly, OCI covers office visits less the applicable co-pay while CareFirst does not cover office visits. See Attachment 1, p. 3. Finally, CareFirst offers mental health and substance abuse coverage for inpatient treatment only, while OCI offers 80% coverage for outpatient the first five outpatient visits, 65% for visits 6 to 30 and 50% for over 31 visits. See Attachment 1, p. 4. It is evident that comparing prices for the SAAC product is difficult due to the variation in benefits and cost sharing between the products.

The same holds true with medically underwritten policies. For CareFirst's medically underwritten insurance product in 1999, coverage for a 35-year-old individual costs approximately $103, $87, or $36 per month depending on the deductible option of $500, $1,000, or $10,000, respectively. See Attachment 6, p. 1. By contrast, the Freestate HMO Personal Plan for a 35-year-old costs $213 monthly. Again, it is almost impossible to draw any conclusions based on price because these products differ dramatically in their cost sharing arrangements. While the Freestate premium is more than two times that of the insurance product's premium, the Freestate product has no deductible while the indemnity has deductible options. See Attachment 6, p. 1. In addition, the Freestate plan covers in full inpatient hospital services, mammography, outpatient diagnostic lab and x-rays, hospice care, and inpatient mental health and substance abuse, while the indemnity covers those services less the applicable deductible and co-insurance. See Attachment 3, pp. 2, 3, 4. Further, the HMO plan covers in full maternity services including inpatient and office visits, while the insurance plan covers maternity services only after a 9-month waiting period, less a deductible and co-insurance. See Attachment 3, p. 2. In sum, cost sharing and premiums may vary substantially among the medically underwritten products.

The rates for the small group product available to the self-employed are easier to compare than the other nongroup products. First, the benefit plan is standard, and second, the cost-sharing for each type of product is uniform. See COMAR 31.11.06. This allows for a true rate comparison among the carriers for like products. In 1999, the average monthly rates are approximately $195 for an HMO plan, $181 for a POS plan, $238 for a PPO plan, and $345 for an indemnity plan. See Attachment 11, p. 1.

C. Trends in Premium Costs for Non-Group Products

The rate increases from 1997 to 1999 in the nongroup market are substantial in the SAAC, medically underwritten and the small group market,[15] although the smallest range of increase among products occurred in the small group market. The rate increases in the SAAC market since 1997 range from 9.5% to 57%, with the exception of a 28.12% decrease for OCI. OCI cut its rates to increase its SAAC enrollees, at the HSCRC's request to increase SAAC enrollees for OCI to participate in the SAAC program. See Attachment 5, p. 2. The 57% increase in the SAAC rates of GHMSI occurred in seven increments since August 4, 1997, and the rate increases alternated due to increased drug benefit coverage or to increased medical coverage[16]. In real dollars, the premium amount prior to August 4, 1997 was $115.00 for an individual, and increased to $182 on July 1, 1999. See Attachment 5, p. 3. OCI's decrease in premium went from approximately $252 for a 35-year-old individual on August 4, 1997, to approximately $181 on December 29, 1998 for the same coverage. See Attachment 5, p. 3.

The rate increases in the medically underwritten product market since 1996 range from 3.7% to 49%. See Attachment 6, p. 3. Most rate increases were large: GHMSI increased their rates three times beginning on January 1, 1998 through April 1, 1999, resulting in an approximate 49% cumulative increase (since 1996). CareFirst increased its rates 29%, and Freestate's increase was 40% on its Personal Advantage Plan[17]. See Attachment 6, p.3. For example, FreeState's monthly premiums for a 35-year-old individual prior to December 1, 1997 was $111; on September 1, 1999 it was $133. See Attachment 6, p.3. OCI's rate increase was modest, at 3.7%. See Attachment 6, p.3. OCI's premium charge for a 35-year-old individual coverage was $150.21 on May 27, 1997; approximately two years later it was $155.79. See Attachment 6, p. 4. However, the amount of cost sharing on benefits differs substantially, even between two HMO plans.[18]

The small group market rates for the self-employed also increased from 1996 to 1999, according to the rates filed with the MIA. It should be noted, however, that the self-employed are a very small part of the entire small group market, which, in general, experiences about an 8% increase, per year. For self-employed individuals enrolled in HMOs, the average rate increase was 36.4% or $52.09 in premiums over this three-year period. See Attachment 11, p. 1. The average POS increase was 39%, or $50.78 in premium, and the average percentage increase for PPOs for the same time period was

[15] Rates for the conversion and HIPAA products were unavailable.
[16] GHMSI does not age band for its premium rates.
[17] Freestate's rate increase was 14.1% in the under-30 age band, 19.8% in the 30-39 age band, and 43.9% in the over-60 age band, which has few subscribers.
[18] Freestate imposes no out-of-pocket limit on its members; OCI has a $1,400 and a $3,800 out-of-pocket limit for individual and family respectively. See Attachment 3, p. 1. Inpatient hospital services are covered in full under OCI, while Freestate's Personal Advantage coverage is less a $500 co-pay per member per year. See Attachment 3, p. 2. An OCI member pays a $50 co-pay per visit for outpatient hospital services, while the Freestate plan member's co-pay is $15. See Attachment 3, p. 2. For mental health substance abuse inpatient services, the OCI member is covered in full, while the Freestate member pays a $500 co-pay. See Attachment 3, p. 4.

39.6%, or $67.67 in premium. See Attachment 11, p.1. Finally, for indemnity plans, the average increase was 42.5%, or $103.02 in premium dollars. See Attachment 11, p. 1. Therefore, the percentage increase range for all delivery systems in the small group market for individual policies was closer, ranging from 36% to 42%, as compared to the large percentage swings in the SAAC market, ranging from a 15% to 56% increase, and a 28% decrease. Similarly, the medically underwritten market showed large increases among products of between 3.7% to 49%.

IV. SAAC

A. Background

Since it started setting hospital rates, the Health Services Cost Review Commission ("HSCRC") has recognized that certain underwriting practices of third party payers can reduce hospital uncompensated care and thus reduce hospital costs. In 1974, the Substantial, Available, and Affordable Coverage ("SAAC") differential was established by the HSCRC to pass along these cost savings to carriers that provide comprehensive, affordable coverage to individuals who otherwise would be uninsured.

The HSCRC based the magnitude of the differential (4%) on an estimate of the reduction in hospital uncompensated care provided by SAAC. The differential is budget neutral for hospitals; hospitals receive their full HSCRC-approved revenue because their rates are marked up to hold them harmless for the amount of SAAC differential claimed against their charges. The increase in charges to non-SAAC carriers through this mark-up, however, should be no greater than they would have been in the absence of SAAC. That is, the marked-up rates should reflect the higher charges hospitals would have if the individuals covered by SAAC were uninsured.

In 1985, the HSCRC held a series of hearings to reexamine the SAAC differential. At that time, the HSCRC determined that carriers could qualify for SAAC if they provided affordable products for individual open enrollment, group conversion, and small groups. Using data on hospital claims for these three types of coverage, the HSCRC reaffirmed 4% as the appropriate amount of differential. Since these hearings, however, many changes have occurred in the regulation of health insurance. Small groups now have access to substantial and affordable coverage as a result of the reforms passed by the General Assembly in 1993. State and federal law (e.g., COBRA, the Health Insurance Portability and Accountability Act) now mandate several forms of group conversion coverage.

In 1997, in response to concerns about the uniformity and comprehensiveness of the benefits in the SAAC products, the General Assembly granted the authority to the Health Care Access and Cost Commission ("HCACC," now the Maryland Health Care Commission), in consultation with the Maryland Insurance Administration, to develop a benefit package for the SAAC market. HCACC convened a broadly representative task force, which included SAAC carriers, to study this issue. The consensus recommendation of this task force was to use the existing Comprehensive Standard Health Benefit Package (CSHBP), developed for the small group market, in the SAAC market as well. Regulations implementing this benefit package were delayed in early 1999. These regulations were scheduled to be adopted in December 1999. Concerns regarding the implications of these regulations on the pricing of certain PPO products in the SAAC market have led to further delays until July 1, 2000 (see COMAR 10.15.01).

In 1998, the HSCRC amended the SAAC regulations to require carriers to reapply for the SAAC differential each year. Four carriers (CareFirst/Blue Cross Blue Shield, NYLCare,

Prudential, and Optimum Choice) applied for the differential in 1999. The HSCRC had serious concerns as to whether the avoided uncompensated care was commensurate with the differential earned by these carriers in the prior year. For example, CareFirst earned $31 million in SAAC differential in calendar year 1998 but, by the Commission's estimate, CareFirst averted only $3.9 million in hospital uncompensated care. (Similar data are available for all four carriers in the attachment following this section). The Commission granted conditional approval to all four carriers until December 15, 1999. The Commission instructed each carrier to develop a corrective plan to bring into balance the value of the differential and the amount of hospital uncompensated care reduced by the carrier. It was the Commission's hope that carriers would pursue one or more of the following corrective strategies: reduce SAAC premiums; improve SAAC benefits; and enroll more uninsured individuals.

B. Work of the Task Force

The Task Force to Study the Non-Group Health Insurance Market looked at insurance coverage for those with a preexisting medical condition who could most likely not purchase a medically underwritten product. After examining a variety of programs from other states, including high-risk pools and guaranteed issue products with "play or pay" mechanisms, the Task Force concluded that the SAAC program still represented the best alternative for providing coverage for the medically uninsurable. The Task Force did believe, however, that the SAAC program should be modified to make it more affordable and comprehensive to reflect the current way that medical services are delivered; (e.g., more emphasis on outpatient care). In addition, the Task Force believed that SAAC carriers were overcompensated relative to the coverage they provided under the existing arrangements.

The Task Force dedicated several of its initial meetings to examining the SAAC issue. The Task Force listened to presentations by the HSCRC, CareFirst, Optimum Choice and Aetna/USHealthcare regarding the status of the program and possible reform strategies. CareFirst and Optimum Choice presented data on premiums and coverage. The group discussed a variety of funding formulas. The areas generating the most discussion included the appropriate application of the subsidy and whether it should apply to open enrollees only or other populations as well, the amount of the carrier subsidy, and incentives for participation in the program. A sub-committee of the Task Force was convened and met once to consider technical changes to the SAAC program.

Another source of discussions was the SAAC benefit plan. One carrier felt the benefit plan, as proposed, was "too rich" for its indemnity/PPO product and presented a low option alternative. The Task Force expressed some interest in offering both a high and low option benefit plan. However, the group believed the issue of redesigning the proposed plan, benefit by benefit, was too complex for the group.

C. Conclusions and Recommendations

The Task Force arrived at the following conclusions:

1) SAAC should not be narrowly focused only on reducing the cost of hospital uncompensated care, but instead, should look more broadly at how carriers subsidize the premiums of comprehensive insurance products to make coverage more available and affordable.

2) SAAC should not simply hold carriers harmless for subsidizing high risk individuals, but should provide an incentive for carriers to provide affordable coverage for populations that would otherwise be uninsured.

3) Benefit design issues for the SAAC product should be reviewed by a workgroup convened by MHCC (formerly HCACC) who designed the current proposed benefit plan.

Based on these findings, the Task Force proposes that the Maryland General Assembly enact legislation, whenever necessary, to codify the following changes into the Insurance Code of Maryland:

SAAC Funding Formula

1) The SAAC differential granted to carriers in recognition of their providing open enrollment in the nongroup market should be 2%.

2) The public benefit of SAAC should be measured in terms of how much the premium for the open enrollment product has been subsidized by the carrier to make it more affordable for the individual.

3) The subsidy of the SAAC product should be defined as all expenditures for healthcare services in excess of 70% of the total premium for the SAAC product. The Task Force felt 70% was a reasonable loss ratio as compared to the standard statutory loss ratio of 60% in the individual market[19] and 75% in the small group market.

4) The test to determine whether a carrier has earned the differential should be to compare the value of the 2% differential to the carrier, (the difference between what the carrier would have paid for hospital services absent the differential minus what the carrier paid for hospital services with the differential), to the amount the carrier subsidized the open enrollment product, times two. In general, the Task Force believed allowing carriers to retain benefits up to twice their subsidy would be an

[19] Insurance Article §15-605(c)(2)

incentive to participate in the program.[20] Any economic benefit above two times the subsidy would have to be returned by the carrier. This could be done by making a payment to the HSCRC or its designee or by lowering the carrier's differential.

Operation of SAAC

5) The Insurance Commissioner should:

   a) Require a SAAC carrier's open enrollment premiums to be ***at least*** 5% higher than the small group market premiums or benefit-equivalent medically underwritten, individual product premiums;

   b) Prohibit specific age or geography banding of the SAAC product's community rate. However, by shadow pricing the SAAC product with the small group product, as recommended in 5a, age and geography will be taken into account since rate banding for these factors is allowed in the small group market.

6) Carriers should, at a minimum, hold two standard month-long open enrollment periods, per year, that meet current HSCRC advertising requirements. In order to allow consumers to better compare premium prices, all SAAC carriers should market their products in January and July to become effective within a month. Carriers can hold more than two open enrollment periods if they choose.

7) Advertising the SAAC product should: a) occur at least twice a year in conjunction with the open enrollment period; b) be encouraged by executive branch agencies through public service announcements, fliers, etc., whenever feasible; and c) be promoted by requiring all individual market carriers (SAAC and non-SAAC) to send consumers information about the SAAC program, along with letters of declination for medically underwritten coverage.

Discussion

The issue of whether the SAAC subsidy should apply to the SAAC population only, or to other populations as well, was debated at length by the Task Force. Specifically, the issue focuses on whether the self-employed, HIPAA eligibles, and enrollees in other nongroup products, such as group conversion and medically underwritten products should be included in the calculation of the subsidy. CareFirst testified that it believes it engages in other underwriting practices that provide significant public benefit (See minutes of 11/22/99 meeting in Appendix C). On the other hand, MAMSI believes the

[20] At least two SAAC carriers did not support this recommendation.

incentive offered to carriers in the SAAC program is a hospital rate differential, not a discount. This means that other third party payers and private pay patients pay more in hospital rates to generate the funds for the SAAC differential. The SAAC program must balance the public policy goal of assuring access to health care coverage for the medically uninsurable with the public policy goal of affordable hospital costs for all payers.[21]

For the self-employed, the issue is even more complex since these individuals are currently covered in either the small group market, where medical underwriting is not permitted, or in a medically underwritten individual market product of their choice. Supporters of moving the self-employed from the small group product to the SAAC program contend that the poor risk of the self-employed who seek out a guaranteed issue product in small group market pollutes the entire risk pool, thus raising premiums for all small employers. Brokers noted many carriers have stopped paying commissions for self-employed business. Those who questioned moving the self-employed noted that problems of individuals moving in and out of small group coverage based on anticipated need were not limited to the self-employed. This behavior is also characteristic of groups with 1-5 persons. It was suggested that other means, such as reinstituting pre-existing condition requirements for very small groups, might better address this problem. Moreover, it was noted that the self-employed constitute a very small percentage of the small group, as a whole, and, therefore, their ability to pollute the pool is limited.

Because the extent and experience of only one carrier with the self-employed is known at this time, the Task Force recommended getting more information on this issue. Similarly, issues raised on the use of the HIPAA product in the evaluation of the subsidy awarded to a carrier in the SAAC market were not easily resolved. These included issues of equity since all carriers must offer HIPAA but only SAAC carriers would get a subsidy for doing so, availability of the product since HIPAA must be available throughout the year to an eligible and the small number of HIPAA eligibles.

Ultimately, the Task Force decided to apply the 2% subsidy incentive formula to SAAC only and to explore the possibility of crediting further coverage to the subsidy after submission of the interim report. Some members, however, still expressed reservations about the manipulation of the SAAC incentive to move consumers from medically underwritten products into SAAC, with the effect of a carrier earning more subsidies.

The Task Force agreed to reconvene to further discuss these issues after the 2000 session of the Maryland General Assembly and for staff to gather additional information in the meantime.

[21] Memo to MIA and MHCC from MAMSI, 12/10/99.